Behavioral Health Integration

Data and Evaluation Workgroup

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Agenda

- Background on Behavioral Health Integration and Medicaid
- Review meeting schedule and objectives
- Review data sources
- Review policy questions and data template
- Discussion

Behavioral Health Integration

- As part of the FY 2012 budget, the General Assembly asked the Department of Health and Mental Hygiene to convene a workgroup and provide recommendations "to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues"
- After a workgroup process, a Consultant's Report was published outlining two potential integration models for Maryland

- While this report was comprehensive, Secretary Sharfstein felt more work needed to be done before a model could be chosen
- In early 2012, a Steering Committee was selected with representation from:
  - DHMH
    - Office of Health Care Financing
    - Office of Behavioral Health and Disabilities
  - MHA
  - ADAA
- Stakeholder meetings are being held to inform these efforts
- Recommendation to be made by September 30, 2012

Workgroups

- Four workgroups have been created to provide insight into critical areas:
  - **Linkage**
  - **State and Local Roles**
  - **Chronic Health Homes**
  - **Data and Evaluation**

Behavioral Health Post-2014

- Under federal health reform law, all health plans must cover behavioral health services
- Medicaid Expansion makes most adults under 138% FPL eligible for Medicaid
- Beginning Jan 1, 2014, financing of behavioral health services is likely to shift from grant-funded to Medicaid or private insurers
- As a result, these efforts are to select a finance and integration model for **Medicaid-financed behavioral health services only**.

Potential Models

Model 1: Protected Carve-In

Medicaid-financed behavioral health benefits would be managed by Medicaid managed care organizations (MCOs) through a "protected carve-in". The MCOs would be responsible for managing a comprehensive benefit package of general medical and behavioral services. Contractual conditions would require the MCOs to employ specific behavioral health practitioners in clinical leadership positions, would specify the credentials of staff who performed behavioral health utilization management, and would put the MCOs at risk for demonstrating that they were assuring access to the behavioral health benefit. This model would protect funds spent on behavioral health treatment but would allow the MCOs to have flexibility in how they structured care coordination, utilization management, etc.

Potential Models

Model 2: Risk-Based Service Carve-Out (presented in consultant report)

Medicaid-financed specialty behavioral health benefits and the State/block grant-funded benefit package would be managed through a risk-based contract with one or more Behavioral Health Organizations (BHO). Contractual conditions would be aligned with those of the Medicaid MCOs; performance standards would be robust and performance risk would be shared with MCOs for continued implementation of health homes for persons with behavioral health conditions, as well as health homes for persons with chronic medical conditions and for improvement in health outcomes for persons enrolled in health homes. The services delivered through the BHO would be specialty behavioral health services. MCOs would continue to provide specified behavioral health care typically associated with primary care providers.

Potential Models

Model 3: Risk-Based Population Carve-Out (new)

As in Model 1, all Medicaid-financed behavioral health benefits and general medical benefits would be delivered under a comprehensive risk-based arrangement. In this model, however, Medicaid would competitively select one or more specialty health plan(s) to manage the comprehensive benefit package for individuals with serious behavioral health diagnoses. If such a diagnosis is present, the person would be enrolled in a specialty health plan, which would be required to deliver the full array of behavioral health and medical benefits. If such a diagnosis is not present, the person would be enrolled in a traditional MCO to receive his/her full array of behavioral health and general medical benefits.

What is being asked of this workgroup?

- Determine what data is available and relevant to the ultimate recommendation of a model
- Make a recommendation on potential measures to evaluate any selected model

What is *not* being asked of this workgroup?

- Evaluating the complete Behavioral Health system
- Evaluating services financed through state-funded grant programs
- Providing data or analysis that is not actionable

Maryland Medicaid Enrollment

- In FY 2011, there was an average of 870,000 enrollees with full benefits (18% increase)
  - 82% in Managed Care Organizations (MCOs)
  - 18% fee-for-service (FFS) - mostly dual eligibles, individuals in spend-down categories, in nursing home or long term care

- Currently, there are more than 1 million people enrolled

- Cost is projected to be $6.2 billion Total Funds (federal and state funds) for FY 2011 (not including DDA and MHA)

- In FY10, Maryland Medicaid consumed about 25% of State budget (compared to 22% nationwide)

HealthChoice Managed Care Program

- In 1997, Managed Care Organizations (MCOs) became responsible for providing the majority of Medicaid services
- Currently, 7 MCOs serve over 774,000 enrollees
- The FFS and HealthChoice benefit package is the same with the exception of small add-ons by MCOs
- MCOs receive a monthly capitation payment for each enrollee
  - Benefit package includes substance abuse services and mental health services provided by PCPs

HealthChoice Carve-Outs

- 33% of services are carved-out of HealthChoice and available on a fee-for-service (FFS) basis, mostly for specialty mental health, long-term care and health-related special education services.
- Carve-outs include:
  - Public Mental Health System (NOTE: MCO do pay for MH services provided by PCPs*)
  - CF-MR
  - Health-related special education services (IFSP and IEP)
  - Nursing home and any long-term facility more than 30 days
  - Personal Care and Medical Day Care
  - Transportation
  - Home- and Community-based Waiver Services
  - Dental care for children and pregnant women (DentaQuest)

* **Data provided by MCOs does not include payment or price information**

Primary Adult Care (PAC)

- PAC Program, which began in July 2006, is a limited benefit package for childless adults under 116% of FPL
- Covered services include:
  - –Primary Care
  - –Limited lab and diagnostic services
  - –Community-based mental health services (carved out of MCO capitated payment)
  - –Community-based Substance Abuse services (carved-into MCO capitated payment)
  - –Pharmacy
  - –Facility fees for emergency room visits
- As of March 2012, there were approximately 62,000 enrollees in PAC

Recent Enhancements to Substance Abuse Program

- Effective January 1, 2010 community substance abuse services were increased
  - HealthChoice and fee-for-service rates were increased (all MCOs and FFS system pay the same rates)
  - Community-based substance abuse services were added to PAC
  - HealthChoice and PAC recipients can self-refer for substance abuse services (OHCQ certified addictions providers don't have to be separately credentialed by MCOs to provide self-referred substance abuse services)

PAC Covered Substance Abuse Services

- Buprenorphine and naloxone
- Community-based SA services were added in January 2010 including:
  - –Comprehensive substance abuse assessment
  - –Individual, family, or group counseling
  - –Methadone maintenance
  - –Intensive outpatient treatment
- Services delivered in hospitals and HSCRC controlled clinics are not covered under PAC
  - -These services <u>are</u> covered under HealthChoice

Codes and Rates for Self-Referred Community-Based Substance Abuse Services

Service	Code	HCPC Description	Unit of Service	New Rate
Comprehensive Substance Abuse Assessment (CSAA)	H0001	Alcohol and/or drug assessment	Per assessment	$142
Individual Outpatient Therapy	H0004	Behavioral health counseling and therapy	Per 15 minutes	$20
Group Outpatient Therapy	H0005	Alcohol and/or drug services; group counseling by a clinician	Per 60-90 minute session	$39
Intensive Outpatient	H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least three hours/day and at least three days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education.	Per diem minimum two hours of service per session Maximum four days per week	$125
Methadone Maintenance	H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	Per week	$80

Meeting Schedule and Objectives

Meeting	**Objective**
May 9 10:00-11:30am	Identify data relevant to model selection
June 6 2:00-3:30pm	Identify data relevant to model selection
July TBD	Develop outcome measures
August 8 10:00-11:30am	Develop outcome measures & Wrap-up

Data Sources

- Medicaid Management Information System (MMIS)
  - MCO Encounter and FFS Claims Data
  - EligibiltyData
  - System Limitations
- Mental Hygiene Administration
  - Claims Data

Objective 1: Identifying Data Relevant to Choosing a Model

- Key Questions to ask:
  - What is the demographic profile of the population?
  - What is the diagnosis profile of the population?
    - Prevalence of MH Diagnosis, SA Diagnosis, Dual Diagnosis
  - What types of services is this population receiving, and in what settings?
  - How does the utilization of different services vary across diagnosis?
  - How does the volume and cost of services financed compare across HC, PAC, and MHA?

Data Template

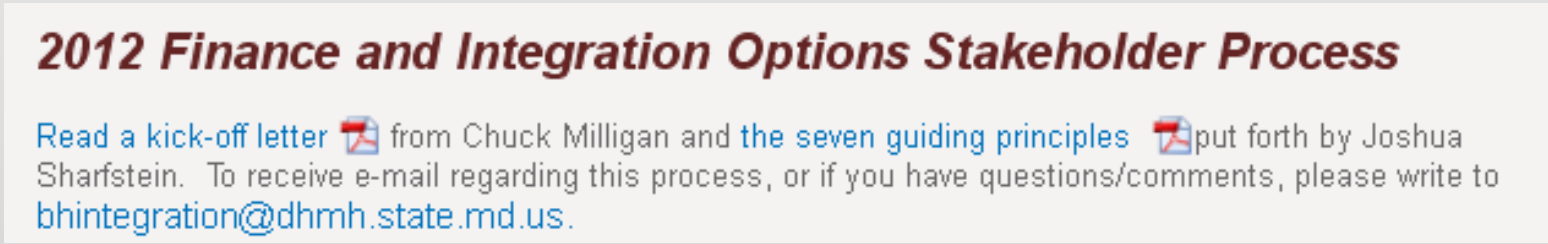
- We have developed a preliminary data template (see handout)
- Open to modifications, provided the suggestions are relevant to the ultimate recommendation of a model

Data Template

Discussion and Comments

BH Integration Website

http://www.dhmh.state.md.us/bhd/SitePages/integrationefforts.aspx



- Submit Comments
- Meetings Schedule
- Resources
- Workgroups

Date, time, location, agenda, and meeting materials for all large group meetings

External documents, web page, and other relevant links

Date, time, location, agenda, and meeting materials for all workgroup meetings

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. We appreciate your feedback!

Commenter:

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup (if applicable):

- ☐ Systems Linkage
- ☐ Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home
- ☐ Other:

Comment:

E-mail all comments and suggestions to bhintegration@dhmh.state.md.us.

Please include the related Workgroup in the subject of your e-mail, if applicable.

Next Meeting

- Evaluation (Data) workgroup*:
  - **June 6, 2012**
    2:00pm-3:30pm
    Maryland Department of Transportation

- Large BH Integration Group Meeting*:
  - **June 5, 2012**

*Date, time, and location are subject to change